

NEW YORK LIFE INSURANCE COMPANY
REQUEST FOR EMPLOYEE PROTECTION PLAN INSURANCE
(Please Print — Use Black Ink)

1. Name of Proposed Insured (Employee)? <u>LORAN EUGENE (SKIP) HALL</u>	2. Date of Birth? Mo. Day Year	3. Place of Birth? <u>NEWTON KANSAS</u>	4. Male? ☒ Female? ☐	5. Account Number? G S.
6. Name of Employer? <u>Duffy's Frontiers Village</u>	7. Exact Job Title? <u>BARTENDER</u>		8. Are you an active full-time employee of the employer, working at least 30 hours per week? Yes ☒ No ☐	
9. Date Full-Time Employment Began? Mo. <u>6</u> Day <u>4</u> Year <u>67</u>	10. Basic Weekly Earnings? <u>126.00</u>	11. If Married, Give Age of Spouse?	12. Number of Eligible Children, if any? <u>none</u>	
13. Beneficiary (subject to change as provided in policy). Full Name & Relationship to you? <u>ANN ELIZABETH HALL (WIFE)</u>			14. Term Insurance Amount? \$ <u>2,000</u>	

I hereby declare that to the best of my knowledge and belief I am eligible for Employee Protection Plan Insurance, and hereby request the insurance to which I am entitled, or to which I may become entitled, under the terms of the group policy or policies issued to my employer by New York Life Insurance Company.

Date Signed 7-23-67

Your Signature Loran E. Skip Hall

EPP-50-C 12-65 Printed in U.S.A.

For New York Life Use Only	Account Number	Eff. Date	ID No.	Class	Due Date	DC	Yes ☐ No ☐
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ELIGIBILITY FOR MEDICARE

Employee Eligible for Medicare Yes ☐ No ☐

Spouse Name _____

Date of Birth _____

Eligible for Medicare Yes ☐ No ☐